U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue date: 02Jul2002

In the Matter of	:	
	:	
Rachel Rife, on behalf of	:	
Franklin D. Rife (deceased),	:	
	:	**Case No.**: 2002-BLA-33
Claimant	:	
	:	
v.	:	
	:	
Island Creek Coal Company,	:	
Employer	:	
	:	
and	:	
	:	
Director, Office of Workers' Compensation Programs,	:	
Party-In-Interest	:	
	:	

REPRESENTATIVES:

Ron Carson
For the Claimant

Douglas Smoot, Esq.
For the Employer

BEFORE:

LINDA S. CHAPMAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS ON MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901, *et seq*. ("Act"). In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensations Program for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was scheduled in this matter on February 26, 2002, in Abingdon, Virginia. However, by letter dated January 25, 2002, Mrs. Rife indicated that she would like a decision on the record, without the necessity of a hearing. Neither the Director nor the Employer objected; therefore, I granted the request, and gave the parties the opportunity to submit additional exhibits into the record, or to make objections to any proposed exhibits. By Order dated May 13, 2002, Employer's Exhibits 1 through 6 were admitted into the record, and the parties were allowed thirty days to submit briefs.

I have based my analysis on the entire record, including the exhibits, and representations of the parties and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

JURISDICTION AND PROCEDURAL HISTORY

The decedent miner, Franklin D. Rife, timely filed for black lung benefits on June 9, 1997. (DX 1). On September 3, 1997, the District Director of the Office of Workers' Compensation Programs ("Director") denied the claim on the grounds that Mr. Rife did not establish that he had pneumoconiosis as a result of his coal mine employment, or disability due to coal workers' pneumoconiosis. (DX16). After Mr. Rife submitted an appeal and request for a hearing, an informal conference was held on March 4, 1998, after which Mr. Rife's claim was again denied for failure to establish total disability due to pneumoconiosis arising out of his coal mining employment. (DX 17, 28).

On March 24, 1998, Mr. Rife appealed, and his file was forwarded to the Office of Administrative Law Judges on June 17, 1998. (DX 31, 37). Following a hearing on November 28, 1998, Administrative Law Judge Daniel J. Roketenetz issued a Decision and Order on August 30, 1999 denying benefits. Judge Roketenetz found that Mr. Rife failed to establish the existence of pneumoconiosis or total disability stemming from pneumoconiosis. (DX 45).

On September 14, 1999, Mr. Rife appealed Judge Roketenetz's decision to the Benefits Review Board ("Board"). (DX 46). Mr. Rife died on May 8, 2000; on September 18, 2000, the Board affirmed Judge Roketenetz's decision denying benefits (DX 53). By letter dated November 20, 2000, Mr. Ron Carson of the Stone Mountain Health Services, on behalf of Mrs. Rachel Rife ("Claimant"), submitted a medical opinion by Dr. Dinkar N. Patel, dated September 10, 2000, in support of a request for modification. (DX 54, 55). The Director denied the request for modification on June 14, 2001, finding that the Claimant failed to prove a material change in

condition because, even though the autopsy report and reviews established that Mr. Rife had a very mild case of pneumoconiosis as a result of his coal mining employment, the autopsy report and reviews failed to establish that he was disabled due to coal workers' pneumoconiosis. (DX 60).

Claimant requested a formal hearing before an administrative law judge and the case was referred to this office on October 1, 2001. (DX 61, 64).

ISSUES PRESENTED

The primary issues contested by the Director and Employer are:

1. Whether the claim was timely filed;
2. The length of Mr. Rife's coal mine employment;
3. Whether Mr. Rife had pneumoconiosis;
4. Whether Mr. Rife's pneumoconiosis arose out of his coal mine employment;
5. Whether Mr. Rife was totally disabled;
6. Whether Mr. Rife's disability and subsequent death was due to pneumoconiosis;
7. Whether the Claimant has established a mistake in a determination of fact.

The Director does not contest the timeliness of the claim or the length of Mr. Rife's coal mine employment. (DX 37, 64).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made.

Background

The miner, Franklin D. Rife, was born on February 22, 1936, and died on May 8, 2000. (DX 1, 52). He had a fourth grade education. (DX 1). He married his wife, Rachel, on October 31, 1955. (DX 10). At the time of his death, Mr. Rife was married and living with his wife, who has not remarried since his death. I find that the Claimant, Rachel Rife, is the eligible survivor of the deceased miner.

Length of Coal Mine Employment

Mr. Rife and the Claimant alleged that Mr. Rife had forty years of coal mine employment. (DX 1, 57). The Director found that Mr. Rife had approximately thirty-two years of coal mine employment. (DX 37, 60). The evidence of record, which includes Mr. Rife's social security earnings statement as well as the personnel records of the Employer, is consistent with the Director's findings. Additionally, I note that in the proceeding before Judge Roketenetz, the

Employer stipulated that Mr. Rife had thirty years of coal mine employment, and based on the record, Judge Roketenetz found that he had thirty-two. (DX 45). Therefore, I credit Mr. Rife with at least thirty-two years of coal mine employment.

Responsible Operator

Under the regulations, liability for benefits under the Act is assessed against the most recent coal mine operator which meets the requirements set out in 20 C.F.R. §§ 725.492, 725.493. The Employer does not contest its status as responsible operator. (DX 64). As the record clearly indicates that the Employer was the last operator for whom Mr. Rife worked as a coal miner for a period of at least one year, I find that Island Creek Coal Company is properly designated as the responsible operator for this claim.

Timeliness of the Claim

The Employer also contests the timeliness of the claim. Mr. Rife's original claim was filed on June 9, 1997. 20 C.F.R. § 725.308 provides that

> A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later.

The regulations also provide that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). The Board has held that a determination of total disability due to pneumoconiosis must be "actually received" by the miner, and if so, there must be a finding that the miner was capable of understanding the report. *Adkins v. Donaldson Mine Co.,* 19 B.R.R 1-34 (1993).

There is nothing in the exhibit record to indicate that Mr. Rife was diagnosed with a total disability due to pneumoconiosis at any time before he filed his application on June 9, 1997. Given the presumption that a claim is timely filed, and the total lack of any evidence to rebut this presumption, I find that the claim for benefits was timely filed.

APPLICABLE STANDARDS

Because this claim was filed after the enactment of the Part 718 regulations, the Claimant's entitlement to benefits will be evaluated under Part 718 standards. In order to establish entitlement to benefits under Part 718, the Claimant must prove that Mr. Rife had pneumoconiosis, that it arose out of his coal mine employment, and that the pneumoconiosis caused him to be totally disabled.

Elements of Entitlement

Under this Part, the Claimant must establish, by a preponderance of the evidence, that: 1) Mr. Rife had pneumoconiosis; 2) that his pneumoconiosis arose from coal mine employment; 3) that he was totally disabled; and 4) that he was totally disabled due to pneumoconiosis. *Greenwich Collieries v. Director, OWCP*, 512 U.S. 267 (1994); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-5 (1986)(*en banc*); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (*en banc*). Failure to establish any of these elements precludes entitlement to benefits. 20 C.F.R. §§§§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-26, 1-27 (1987).

Modification

In evaluating a modification request based on an alleged change in conditions, an administrative law judge is required to undertake a *de novo* consideration of the issue by first independently assessing the newly submitted evidence to determine whether it is sufficient to establish the requisite change in conditions. If a change is established, the administrative law judge must then consider all of the evidence of record to determine whether the claimant has established entitlement to benefits on the merits of the claim. *Kovac v. BNCR Mining Corp.,* 14 B.L.R. 1-156 (1990, *modified on reconsideration,* 16 B.L.R. 1-71 (1992).[1] *See also, Nataloni v. Director, OWCP,* 17 B.L.R. 1-82 (1993) and *Kingery v. Hunt Branch Coal Co.,* 19 B.L.R. 1-8 (1994). In *Kingery*, the Board, citing its decisions in *Kovac* and *Nataloni*, described the proper scope of the *de novo* review of a modification request as follows:

> [A]n administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Id. at 11.

In determining whether a mistake of fact has occurred, the administrative law judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keete v. Aerojet-General Shipyards, Inc.,* 404 U.S. 254, 256 (1971). *See also, Jessee v. Director, OWCP,* 5 F.3d 723 (4th Cir. 1993). The Board has also held that the Administrative Law Judge should always review the record on modification to assess whether a mistake of fact has occurred. *Kingery, supra.* The Sixth Circuit, in which this case arises, has stated that a

---

[1] In its decision on reconsideration, the Board modified its holding in *Kovac* by stating that new evidence is not a prerequisite to a modification based on an alleged mistake in a determination of fact; rather, "[m]istakes of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on the evidence initially submitted." *Id.* at 73.

modification request need not specify any factual error or change in conditions. *Consolidation Coal v. Director, OWCP (Worrell)*, 27 F.3d 227 (6th Cir. 1994). The Claimant may merely allege that the ultimate fact, total disability from pneumoconiosis, was incorrectly decided. Additionally, the Court stated that the administrative law judge has the duty to reconsider all of the evidence for a mistake of fact or a change in conditions. *Id.*

In his August 30, 1999 decision, Judge Roketenetz found that Mr. Rife was not entitled to benefits because he failed to establish any element of entitlement. (DX 45). Judge Roketenetz accurately summarized the medical evidence of record. He found that the x-ray evidence and physician opinion evidence did not establish the existence of pneumoconiosis; he also found that none of Mr. Rife's pulmonary function study or arterial blood gas study results qualified to establish the existence of a totally disabling respiratory or pulmonary condition at §§718.204(c)(1) or (c)(2). He found no evidence indicating that Mr. Rife suffered from cor pulmonale with right-sided congestive heart failure to establish the existence of a totally disabling respiratory or pulmonary condition at §718.204(c)(3). Nor did he find that the preponderance of the physician opinion evidence established that Mr. Rife suffered from a totally disabling respiratory or pulmonary condition at §718.204(c)(4).

I find that there was no mistake of fact in Judge Roketenetz's factual determinations, and the discussion and analysis of the medical evidence submitted and considered in Mr. Rife's previous denial by Judge Roketenetz is hereby incorporated into this decision on modification. (DX 45). In addition, the following evidence was submitted after Judge Roketenetz's decision, and it will be considered, in conjunction with the evidence before Judge Roketenetz, in determining if the Claimant has established a change in conditions.

Dr. Dinkar N. Patel

Dr. Patel submitted a letter, dated September 10, 2000, stating that he treated Mr. Rife, who had chronic obstructive pulmonary disease and coal workers' pneumoconiosis. According to Dr. Patel, Mr. Rife had recurrent admissions with recurrent bronchitis, shortness of breath, cough, wheezing, and amyelotrophic lateral sclerosis. Dr. Patel indicated that Mr. Rife died on May 8, 2000, and that his autopsy report showed pulmonary edema and coal workers' pneumoconiosis. In addition, the microscopic description showed pulmonary edema and congestion, with global emphysema and subpleural fibrosis, as well as scattered dust macules surrounded by focal emphysema, suggesting coal workers' pneumoconiosis. Dr. Patel stated that Mr. Rife had coal workers' pneumoconiosis, for which he received treatment. (DX 54).

Autopsy Report

Dr. Joseph Segen conducted the autopsy on Mr. Rife on May 9, 2000, which was limited to examination of the chest (DX 56).. On gross examination, Dr. Segen noted that there was patchy anthracotic pigment on the pleural surface, and throughout the pulmonary parenchyma. There was a relative increase in firmness, without gross changes of emphysema. On microscopic

examination, Dr. Segen found pulmonary edema and congestion, with global emphysema. There was subpleural fibrosis, and scattered dust macules surrounded by focal emphysema. The bronchiolar mucosa focally demonstrated squamous metaplasia. Dr. Segen's diagnosis was pulmonary edema, emphysema, coal workers' pneumoconiosis, mild, and atherosclerotic heart disease, mild.

Dr. Joshua A. Perper

Dr. Perper reviewed the medical records, and examined 13 autopsy slides, at the request of the Director (DX 58). Dr. Perper's microscopic findings were simple coal workers' pneumoconiosis, very mild, centrilobular emphysema, moderate to severe, and hypertrophy of myocardial fibers, minimal, focal. Dr. Perper felt that although the pathological examination, which is the gold standard for diagnosing coal workers' pneumoconiosis, showed the presence of simple coal workers' pneumoconiosis, there were no objective signs of pneumoconiosis, as only one reader diagnosed pneumoconiosis by chest x-ray, and repeated pulmonary function and arterial blood gas tests were either normal or showed insignificant abnormalities.

Dr. Perper felt that Mr. Rife's pneumoconiosis was a result of his occupational exposure to coal mine dust, because of his sufficiently long occupational exposure, as well as the presence of combined anthracotic pigment and silica crystals in the pneumoconiotic lesions.[2]

P. Raphael Caffrey

Dr. Caffrey reviewed the medical records, as well as seven of the autopsy slides, at the request of the Employer (DX 59), and testified by deposition on November 14, 2001 (EX 2). Dr. Caffrey found that the 5 slides from the lung, in general, showed acute passive congestion with focal pulmonary edema. There was a moderate amount of recent hemorrhage on the slide from the left lung. Additionally, there was a mild to moderate amount of anthracotic pigment subpleurally around blood vessels and respiratory bronchioles. On the two slides from the right lung, he saw two lesions of simple coal workers' pneumoconiosis, or anthracotic pigment with reticulin and focal emphysema. He saw one similar lesion from the left lung. On two of the slides, which were not identified by side, he saw a lesion of simple coal workers' pneumoconiosis. There were no nodules, and no evidence of malignancy; there was no fibrosis and no evidence of complicated pneumoconiosis. In his opinion, the slides showed a very mild degree of centrilobular emphysema. Based on his review of the slides, Dr. Caffrey concluded that Mr. Rife had pulmonary congestion and edema with focal hemorrhage; simple coal workers' pneumoconiosis, minimal; and centrilobular emphysema, mild.

After his review of the medical records, Dr. Caffrey concluded that Mr. Rife had a minimal degree of simple coal workers' pneumoconiosis, which definitely would not have disabled him

[2] Dr. Perper also discussed the relationship of Mr. Rife's pneumoconiosis to his death, which is not an issue in this claim.

before his death, and did not cause any pulmonary disability. He classified the pneumoconiosis as minimal, because it made up less than 2% of the lung tissue on the slides he reviewed. He also noted that all of the x-ray interpretations by board-certified radiologists and B readers were negative, with the only positive interpretation being by Dr. Sutherland, whom he did not believe was either a board-certified radiologist or B reader.

Dr. Caffrey noted that Mr. Rife suffered from amyotrophic lateral sclerosis, a chronic degenerating neurologic disorder. He stated that such patients usually have respiratory and muscle impairment, and abnormalities in pulmonary function. Progression of respiratory impairment is usually rapid. In his opinion, Mr. Rife's death was the result of his ALS and cardiac problems, and had no relationship to his employment in the coal mining industry.

Dr. Richard L. Naeye

Dr. Naeye reviewed medical records, as well as seven of the autopsy slides, at the request of the Employer (DX 62). On microscopic examination of the slides, Dr. Naeye found a small to moderate amount of black pigment in the subpleural region and adjacent to small arteries and airways. Only one of the deposits in a subpleural location reached 1 mm. in diameter, so that all could be classified as anthracotic macules. Some of the macules had admixed fibrous tissue and small numbers of birefringent crystals. He noted that the few crystals that were barely visible under the highest magnification were toxic free silica, with the rest being non-toxic silicates. There was no focal emphysema, and rare rims of focal emphysema. There was centrilobular emphysema, varying from mild to moderate in severity. There was no microscopic evidence of significant chronic bronchitis or bronchiolitis. He found the most striking abnormalities to be large areas of fresh intraalveolar hemorrhage and the plugging of some airways by admixed mucous, and acute inflammatory and exfoliated cells.

Dr. Naeye noted that there was no description of Mr. Rife's terminal illness, but that postmortem findings suggest that he died as a consequence of his ALS, in that he was too weak to dislodge and cough up mucous and inflammatory cells that had collected in his airways. He felt that there were the minimal findings required for a diagnosis of mild, simple coal workers' pneumoconiosis, including anthracotic macules in the characteristic lung locations for pneumoconiosis, with associated fibrosis and rare rims of focal emphysema. However, the lesions were too small and few in number to cause any measurable abnormalities in lung function, as repeatedly shown by the results of pulmonary function studies. The fact that the lesions could not be seen on x-rays was additional evidence of their small number and size.

Dr. Joseph F. Tomashefski

Dr. Tomashefski reviewed medical records, as well as seven of the autopsy slides, at the request of the Employer (EX 1). His review of the autopsy slides showed relatively well-preserved lung architecture, without significant fibrosis. There was mild centrilobular airspace enlargement, with apparently detached septa. Within the alveolar spaces was proteinaceous

edema fluid. In addition to generalized congestion, there was alveolar hemorrhage, and mild acute inflammation. The bronchi contained mucus and a neutrophilic exudate. There was mild chronic inflammation of the bronchial walls. Dr. Tomashefski noted increased black pigment in the visceral pleura and alveolar septa. A few of the deposits of black pigment were associated with respiratory bronchioles, and qualified as coal macules with surrounding focal emphysema. These macules were less than 1mm. each, and in all, occupied much less than one percent of the lung parenchymal tissue on the slides.

Having reviewed the slides as well as the medical reports, it was Dr. Tomashefski's opinion that Mr. Rife had mild centriacinar emphysema, acute pulmonary congestion and edema, probably secondary to terminal heart failure, and mild acute bronchitis and bronchopneumonia. Based on the presence of a few small coal macules with focal emphysema, he also felt that Mr. Rife had minimal simple coalworkers' pneumoconiosis. According to Dr. Tomashefski, the minimal simple coalworkers' pneumoconiosis was essentially an incidental histologic finding which would have caused Mr. Rife no respiratory symptoms or respiratory impairment. He noted that the minimal nature of the pneumoconiosis was consistent with his clinical radiographic data that overwhelmingly showed an absence of changes consistent with pneumoconiosis. He felt that Mr. Rife's respiratory symptoms and lung function abnormalities could best be explained by his centriacinar emphysema and reactive airways disease, and that neither simple coalworkers' pneumoconiosis, coal dust exposure, or coal mine employment were a cause of the centriacinar emphysema, reactive airways disease, or amyotrophic lateral sclerosis. He noted that anatomically, the lesions of centriacinar emphysema bore no specific spatial relationship to the sparse, small coal macules. Dr. Tomashefski felt that Mr. Rife was totally disabled due to his ALS, but not due to his simple coal workers' pneumoconiosis.

Dr. W.K.C. Morgan

Dr. Morgan reviewed medical records at the request of the Employer (EX 3). Based on his review, Dr. Morgan concluded that there was just sufficient evidence to justify a diagnosis of coal workers' pneumoconiosis. He noted that the changes were relatively minimal, as they did not show up on x-ray but were detected at autopsy. Dr. Morgan stated that at the time he died, Mr. Rife had severe pulmonary and respiratory impairment as a consequence of his amyotrophic lateral sclerosis, which causes increasing weakness of the respiratory muscles. Additionally, he was being fed through a tube and had a tracheostomy. Mr. Rife also had cardiac problems. In Dr. Morgan's opinion, before he developed ALS and cardiac problems, Mr. Rife was quite capable of working in the mines, and had adequate respiratory reserve to do so. He felt that none of his problems were related to his former coal mine employment, nor did it cause any impairment before his death. According to Dr. Morgan, the minimal simple coal workers' pneumoconiosis that Mr. Rife had would in no way have affected or caused any disability or impairment.

Dr. Stephen T. Bush

Dr. Bush reviewed the medical records and seven of the autopsy slides at the request of

the Employer (EX 4). He found that the lungs showed evidence of a very mild degree of simple coalworkers' pneumoconiosis. The five slides that were lung tissue showed a small amount of black dust pigment consistent with coal dust beneath the pleura and scattered in the interstitium and about some small airways and blood vessels. He found a few coalworker micronodules represented by dust pigment free in the tissue and in macrophages with a fibrous reaction, surrounded by focal dust emphysema forming lesions up to .2 cm. He found an average of two to three lesions on each slide, mostly .1 cm. According to Dr. Bush, this represents a very limited amount of disease due to coal dust exposure, with no more than 1% of the lung tissue adversely affected.

Dr. Bush concluded that Mr. Rife did not appear to suffer from respiratory impairment before his death. His pulmonary evaluations showed the absence of pulmonary impairment in 1997 and 1998, and his x-ray readings were negative, with the exception of one reading in 1978. His autopsy findings showed a very limited amount of occupational lung change. However, Mr. Rife may have been totally disabled before his death as a result of his amyotrophic lateral sclerosis, which appeared to involve the muscles of respiration.

J. Randolph Forehand

Dr. Forehand reviewed Mr. Rife's medical records at the request of the Employer (EX 5). He noted that in 1997 and 1998, Mr. Rife underwent comprehensive pulmonary evaluations to determine if he had any respiratory disease or impairment as a result of his coal mining employment. He was not found disabled on either occasion, nor did x-rays taken at the time show radiographic evidence of pneumoconiosis. Dr. Forehand noted that coal miners who are disabled with pneumoconiosis are short of breath either from obstructed airways or a lack of oxygen, conditions for which Mr. Rife was tested during his 1997 and 1998 examinations. The results of the pulmonary function and arterial blood gas studies showed that his airways were free of significant obstruction, and that his lungs provided Mr. Rife with an adequate supply of oxygen, giving him the respiratory capacity to work.

Based on his review of the records, Dr. Forehand concluded that Mr. Rife had a significant history of coal dust exposure, and the presence of simple coal workers' pneumoconiosis, despite his normal chest x-rays. However, there was no evidence of any respiratory impairment that might interfere with or reduce his capacity to work. Mr. Rife's capacity to work was compromised by progressive neurological deterioration from debilitating ALS.

Dr. Kirk E. Hippensteel

Dr. Hippensteel examined Mr. Rife on March 11, 1998, at the request of the Employer, and also reviewed medical records. He also testified by deposition on February 11, 2002 (EX 6). Mr. Rife had just recently been diagnosed with amyotrophic lateral sclerosis. Dr. Hippensteel administered an x-ray, which he found to be negative for pneumoconiosis. Mr. Rife's spirometry showed flow rates in the low normal range, which improved into the normal range post

bronchodilator. His MVV was reduced both before and after bronchodilator, with suboptimal tidal volumes that Dr. Hippensteel felt could be affected by his neuromuscular disease. His lung volumes showed no restriction, but suggested some air trapping; his diffusion was normal. The arterial blood gas study showed a normal gas exchange at rest.

Based on the information he obtained, Dr. Hippensteel felt that there was no evidence of coal workers' pneumoconiosis or any coal dust related disease of the lungs. He had normal ventilatory and gas exchange functions, and thus, from a strictly pulmonary standpoint, was able to return to work in the mines at his old job or any job requiring heavy labor. However, his heart disease and his ALS made him disabled as a whole man. These conditions have no relationship to coal mine employment.

After reviewing additional records, Dr. Hippensteel felt that his findings were mostly corroborated. He noted a suggestion of mild restriction on pulmonary function tests that may have been effort related, but was not indicative of any permanent pulmonary impairment from any cause. He also felt that the findings from his examination were also against a diagnosis of pneumoconiosis as a problem for Mr. Rife. In Dr. Hippensteel's opinion, Mr. Rife suffered impairment from nonpulmonary problems with no relationship to coal dust inhalation.

At his deposition, Dr. Hippensteel discussed the additional medical records he reviewed. He noted that Mr. Rife had ALS, a disease of progressive neuromuscular deterioration leading to death, which affects breathing function terminally; respiratory failure is the common mode of death. According to Dr. Hippensteel, the findings of mild pneumoconiosis on autopsy were entirely consistent with the overwhelmingly negative x-ray readings. Dr. Hippensteel acknowledged that an individual could have medical or legal pneumoconiosis in the presence of a negative x-ray, and still have a disabling lung impairment, but that was not the case here. He noted that Dr. Patel indicated he was treating Mr. Rife for chronic obstructive pulmonary disease, and that he had recurrent bronchitis, shortness of breath, cough, and wheezing. However, Dr. Hippensteel did not feel that these factors were related to his pneumoconiosis, as the objective pulmonary function tests showed that he did not have chronic obstructive pulmonary disease, and wheezing and bronchitis spells are known to be a common problem for persons with ALS, who develop aspiration problems due to weakness in clearing secretions, and bronchial irritation. He felt that Dr. Patel could have mistaken these findings as secondary to pneumoconiosis, when in fact they were secondary to ALS.

DISCUSSION

The pathologists and reviewers who have examined the autopsy slides and reviewed the medical records have unanimously agreed that Mr. Rife had evidence of simple coal workers' pneumoconiosis on autopsy. Thus, I find that the Claimant has established a change in condition, and I must now consider all of the evidence of record to determine whether the Claimant has

established entitlement to benefits on the merits of the claim.[3]

Unfortunately, these same pathologists and reviewers also unanimously agree that, although Mr. Rife had pneumoconiosis by virtue of the microscopic autopsy findings, his pneumoconiosis was so mild that it could not have caused any respiratory impairment, much less disability, while Mr. Rife was alive. They have described the findings on autopsy as consistent with the historical x-ray evidence, which is overwhelmingly negative. The conclusion that the pathological pneumoconiosis was too mild to cause impairment is also borne out by the results of the pulmonary function and arterial blood gas study results, as set out in Judge Roketenetz's opinion. On the other hand, the pathologists and reviewers agree that Mr. Rife's ALS, which resulted in his death, also was responsible for the respiratory symptoms he displayed.

It is the Claimant's burden to establish that Mr. Rife was totally disabled due to his pneumoconiosis. The only evidence put forth by the Claimant is the brief letter by Dr. Patel, asserting that he treated Mr. Rife for chronic obstructive pulmonary disease and coal workers' pneumoconiosis, and that he suffered from bronchitis, shortness of breath, cough, wheezing, and ALS. Dr. Patel also recited the findings from the autopsy report. However, even accepting Dr. Patel's totally unsupported claims at their face value, Dr. Patel does not state that Mr. Rife had a totally disabling respiratory impairment due to his pneumoconiosis.

I note that none of the physicians who submitted medical opinions in the claim before Judge Roketenetz found that Mr. Rife had a totally disabling respiratory impairment, much less that it was due to pneumoconiosis. Nor did the pulmonary function and arterial blood gas studies produce results that qualified for the presumption of total disability.

CONCLUSION

Considering all of the evidence as a whole, I find that the Claimant has established by a preponderance of the evidence that Mr. Rife suffered from pneumoconiosis, by virtue of the autopsy evidence.[4] However, I find that the Claimant has not established by a preponderance of the evidence that Mr. Rife suffered from a total respiratory disability due to his pneumoconiosis. Thus, the Claimant is not entitled to benefits under the Act.

ORDER

The claim of Rachel Rife for benefits under the Black Lung Benefits Act is hereby DENIED.

---

[3] I have carefully reviewed the record, and find no mistake of fact in the findings by Judge Roketenetz.

[4] Mr. Rife is entitled to the statutory presumption that his pneumoconiosis arose out of his coal mine employment, a presumption that has not been rebutted.

ATTORNEY'S FEES

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for services rendered in pursuit of this claim.

A

LINDA S. CHAPMAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601,Washington, D.C. 20013-7601. *A copy of a Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.*